TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
American Specialty Pharmacy

**Respondent Name**
Liberty Mutual Insurance Corporation

**MFDR Tracking Number**
M4-15-3212-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
May 29, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Laxacin is **medically necessary:** … to avoid constipation due to opiate derivatives…"

**Amount in Dispute:** $44.30

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Progressive Medical had already billed and been denied reimbursement for this drug for this date of service. A letter was also sent to the treating doctor advising that this drug, which is outside of the ODG, would not be reimbursed without the proper preauthorization."

**Response Submitted by:** Liberty Mutual Insurance

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 3, 2015 | Prescription Medication (Laxacin) | $44.30 | $44.30 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical benefits.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Code was not defined as required by 28 Texas Administrative Code §133.240. CARC definition: "Exact duplicate claim/service."

- U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.

**Issues**

1. Was preauthorization raised in accordance with 28 Texas Administrative Code §133.307?
2. Were the insurance carrier's reasons for denial of payment supported?
3. What is the Maximum Allowable Reimbursement (MAR) of the disputed services?
4. Is the requestor entitled to additional reimbursement?

**Findings**

1. In their position statement, the insurance carrier stated that the prescription "… would not be reimbursed without the proper preauthorization." 28 Texas Administrative Code §133.307 (d)(2)(F) states, in relevant part, "The response shall address only those denial reasons **presented to the requestor prior to the date the request for MFDR** [emphasis added] was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review…"

   Review of the submitted documentation does not support that preauthorization was raised in accordance with 28 Texas Administrative Code §133.307 and consequently, will not be considered in this dispute.

2. The insurance carrier denied disputed services as a duplicate and with claim adjustment reason code "U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review." Medicare defines a duplicate claim as:

   a claim submitted … from the same provider for the:
   - Same beneficiary; for the
   - Same item or service; for the
   - Same date of service.

   Review of the submitted information does not find that the disputed services met the definition of a duplicate claim. The insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. The MAR in for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503 (c), which states, in relevant part:

   (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount…
   (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
   (A) health care provider

   The requestor is seeking reimbursement for the generic medication, Laxacin 8.6-50 mg tablet, NDC number 50488090101. The disputed medications were dispensed on February 3, 2015. The MAR is calculated as follows:

| Date of Service | Prescription Drug | Calculation per §134.503 (c)(1) | §134.503 (c)(2) | Lesser of §134.503 (c)(1) & (2) | Carrier Paid | Balance Due |
|---|---|---|---|---|---|---|
| 2/3/15 | Laxacin 8.6-50 mg tablet | (1.26520 x 100 x 1.25) + $4.00 = $162.15 | $44.30 | $44.30 | $0.00 | $44.30 |

4. The total MAR for the disputed services is $44.30. The insurance carrier paid $0.00. A reimbursement of $44.30 is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $44.30.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $44.30 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | Laurie Garnes | September 4, 2015 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.